A. Purpose, Background and Description of Services

1. Purpose

The State Department of Health Services (DHS), Medi-Cal Managed Care Division (MMCD), is soliciting proposals from firms that are able to provide health services to the beneficiaries of the State's Medi-Cal program in Fresno, Kern (excluding zip codes 93555 and 93556), San Joaquin, Stanislaus and/or Tulare Counties. This Request for Proposal (RFP) solicits proposals for the implementation, operation, and transition of Medi-Cal eligible beneficiaries from fee-for-service Medi-Cal to the Medi-Cal Managed Care Two-Plan Model. There is no cost or price bid associated with this RFP. The State shall set a capitated rate for payment. Appendix 1 is the Two-Plan Model Capitation Rates for the Commercial Plan in Fresno, Kern, San Joaquin, Stanislaus and Tulare Counties.

This procurement is open to all eligible firms and/or individuals that meet the qualification requirements, including commercial businesses, nonprofit organizations, State or public universities (including auxiliary organizations) and other entities. DHS intends to make a separate contract award to the most responsive and responsible firm earning the highest score for each County included in the Central Valley RFP. Fresno County is the exception because there are two (2) Commercial Plans in that county. Therefore, there will be a contract award to the first and second most responsive and responsible firm or individual earning the highest scores for that county.[1]

The Medi-Cal program is continuously modified as a result of Federal and State legislation and regulations, judicial and administrative decisions, and other program mandates. Proposers should be aware that the selected Contractor will be responsible for the planned and orderly adherence to all applicable provisions of Federal and State legislation and regulations and to any changes occurring throughout the term of the contract.

2. Background

In July 1965, the Social Security Act was amended to add Title XVIII, which established the Medicare Program. The amendment also added Title XIX, which established the state-option Medicaid Program, known in California as Medi-Cal. Title XIX provided Federal reimbursement (called "Federal financial participation") to those states that implemented a Medicaid Program.

The State of California implemented Title XIX through legislation signed in November 1965 and the Medi-Cal program became effective in March 1966. Prior to the start of Medi-Cal, indigent Californians were provided health care services through a variety of programs administered by the counties. With the advent of Medi-Cal, a wide range of health benefits became available to California residents whose income and resources were insufficient to meet the costs of necessary medical services without jeopardizing the person's, or family's, self-maintenance and security. The DHS pays on a fee-for-service basis and adjudicates claims for Medi-Cal Services submitted by certified providers.

Federal and State resources fund Medi-Cal. The Federal government contributes approximately 50 percent toward the cost of services related to health care delivery. With few exceptions, the State contributes the balance. The Medi-Cal program is administered by the State in cooperation with the federal and county governments.

[1]Current regulations contemplate that each county will have a Local Initiative and a Commercial Plan Contractor. Fresno County has two (2) Commercial Plan Contractors, as allowed under current regulations, because neither Fresno County nor its stakeholders chose to organize or designate a plan to be its Local Initiative. DHS is seeking confirmation that this is still the position of Fresno County and its stakeholders. Should Fresno County or its stakeholders timely organize or designate a plan to be the Fresno County Local Initiative there will be only one (1) Fresno County Commercial Plan Contract award.

In 1991, Assembly Bill (AB) 336 (Chapter 95, Statutes of 1991) was enacted which directed DHS to emphasize managed care as the means for delivering health care to Medi-Cal beneficiaries. Senate Bill (SB) 485 in 1992 (Chapter 722, Statutes of 1992) provided authority for mandatory enrollment and the transition of Medi-Cal beneficiaries into managed health care plans. DHS responded to this legislation in 1993 by releasing its strategic plan entitled Expanding Medi-Cal Managed Care; Reforming the Health System; Protecting Vulnerable Populations. This expansion plan called for the development of the "Two-Plan Model" in, originally, thirteen (13) California counties with the greatest number of Medi-Cal beneficiaries. The thirteen (13) counties included Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, San Diego, Santa Clara, Stanislaus, and Tulare. San Diego subsequently reorganized as a Geographic Managed Care model. The Two-Plan Model calls for the operation of a Local Initiative (locally organized health plan) and a commercial health plan in each of the remaining twelve designated Two-Plan Model counties.

In 1995, the DHS initiated the procurement of commercial, HMO contractors to participate in the Medical Managed Care, Two-Plan Model program. The successful proposals receiving DHS contracts were with Blue Cross of California, HealthNet (originally Foundation Health Plan), Molina Health Plan, and Omni Health Plan. With the exception of Omni Health Plan, the commercial health plan contracts currently remain in effect. During the 1999–2000 fiscal year, Omni Health Plan, the commercial health plan in Stanislaus County, terminated its contract with DHS. The Local Initiatives came into operation between 1996 and 2000, after obtaining Knox Keene licensure and demonstration of compliance with the Medi-Cal Managed Care Program requirements. They continue to operate under State and Federal sole source authority.

3. The Medi-Cal Managed Care Program

Managed care has become the predominate delivery system for the majority of Medi-Cal beneficiaries in California. Over 3.2 million of California's six (6) million Medi-Cal beneficiaries obtain services from a managed care organization. Since the inception of mandatory enrollment, the purpose of the Medi-Cal Managed Care Program has been to improve access to care and quality of care in a cost-effective manner.

DHS contracts are a compilation of statutory and regulatory requirements as well as program policy. As a purchaser of services, DHS designs contracts to obtain maximum benefits for its expenditures and to achieve measurable positive health outcomes. The contract is designed around several health plan performance areas that reflect the priorities of the DHS and Medi-Cal Managed Care Program.

a. Organization and Administration

Contractors must demonstrate proof of unrestricted licensure as a Knox-Keene health care service plan from the State Department of Managed Health Care (DMHC). Additional DHS requirements on the organization and administration of the entity are found in Title 22, CCR, Section 53840 et. seq. and Sections 53246 and 53200.

The qualities of the Medi-Cal program differ in many instances from the commercial health plan products. Administrative infrastructures must be able to accommodate the range of program and staffing needs to meet all contract requirements. The organization must have experience and skill compatible with public sector contracting and an ability to respond to the legislative environment.

b. Financial Information

To successfully implement and maintain a Medi-Cal Managed Care health plan contract, the Contractor must have a well-documented and prepared business plan, sufficient financial

Indian Health Service Facilities

The Indian Health Care Improvement Act (25 U.S.C., section 1601 et. seq.) and the Snyder Act (25 U.S.C. section 13) establish programs that recognize and address the health care needs of American Indians. These programs, operated by Indian tribes and Indian organizations, are referred to as Indian Health Service Facilities and are required by Federal law to provide services to all eligible Indians who present themselves for care.

Indian Health Service Facilities are another uniquely protected provider of service. American Indians who are Medi-Cal eligible under the mandatory aid codes are not required to enroll in managed health care plans. An American Indian who does enroll in a managed health care plan may access services from any Indian Health Service Facility in the health plan network or any Indian Health Facility out of the health plan network. American Indians enrolled in managed health care plans may disenroll at any time and seek services from Indian Health Service Facilities on a FFS basis.

g. Provider Relations

A cooperative and understanding relationship between the Contractor and all its participating providers is fundamental to the success of the Medi-Cal Managed Care Program. While organized health care is not new to many health care service providers, it is very important that the Contractor provide an environment for clear and open communication between the Contractor and its participating providers regarding Medi-Cal managed care processes. There must be collaborative efforts between the Contractor and its participating providers in ensuring that Medi-Cal members have ready access to care, receive high quality service, and get assistance in the coordination of special services. Good provider relations foster those efforts.

h. Provider Compensation Arrangements

DHS will protect the integrity of the Medi-Cal program by ensuring that Medi-Cal dollars are spent appropriately and fairly. It is the intent of DHS to ensure program funds are directed mainly to provide medical care services.

DHS has an administrative law process for unpaid and/or disputed claims for emergency services rendered by non-contracting providers (Title 22, CCR, Section 53875). While this process is available, DHS expects the Contractor to minimize such administrative law appeals. If such events occur, the Contractor shall respond timely to administrative law hearing notices.

i. Access and Availability

Ready access to health care services is essential for positive health outcomes The lack of a regular physician and timely access to care has resulted in Medi-Cal beneficiaries receiving sporadic care, and having to access primary and urgent care at local emergency rooms. It is the goal of DHS to improve Medi-Cal beneficiaries access to quality health care through a comprehensive coordinated system of care that emphasizes timely access to primary and other necessary services.

Access to Services with Special Arrangements

Medi-Cal members of Managed Care health plans may access certain covered services through Local Health Departments (LHD) and non-contracting providers. These include family planning; sexually transmitted disease; human immunodeficiency virus (HIV) testing and counseling; minor consent; and, immunization services. The Contractor must communicate to Medi-Cal members the availability of these services both within the network and through non-contracting providers. When non-contracting providers provide services to Medi-Cal members, the Contractor is responsible for the coordination of care, necessary follow-up services, and

reimbursement to the non-contracting provider (see Exhibit A, Attachment 8, Provider Compensation Arrangements).

Cultural and Linguistic Services Requirements

The relationship between culture, language, and health care is complex and directly linked to the health outcome of the patient. In a state where the ethnic, cultural and language diversity is woven into the social milieu, meeting the demand for multilingual and cultural services is imperative. See Program Appendices, Appendix 7, Demographics, for current data on eligible Medi-Cal beneficiaries by age, ethnicity and primary spoken language.

j. Scope of Services and Case Management and Coordination of Care

Medi-Cal Managed Care health plan members are entitled to the full scope of benefits as defined in Title 22. Some of these benefits are excluded from health plan contracts and must be accessed through providers and/or programs outside the health plan network. These benefits and programs include: dental, specialty mental health services, California Children Services (CCS); Regional Center services for persons with developmental disabilities; Medi-Cal Home and Community Based Services Waiver for persons with developmental disabilities; Early Intervention Services; Local Education Agency services; Acquired Immune Deficiency Syndrome (AIDS) Waiver services; Direct Observed Therapy for treatment of Tuberculosis, and; Women, Infants and Children Supplemental Nutrition program. Contractor is responsible for the efficient and effective joint case management and coordination of care when Medi-Cal members access these services. A few of these programs are described below:

Specialty Mental Health Services

As the result of specific legislation, the State Department of Mental Health established the Medi-Cal Specialty Mental Health Services Consolidation Program that created mental health plans at the county level. A full description of Contractor's responsibilities, the types of services covered by the local mental health plan, and the types of providers used is published in the Medi-Cal Managed Care Division Policy Letter 00-01 available in the Data and Information Library. See Program Appendices, Appendix 2, Data Library Catalog.

Persons with Developmental Disabilities

In California, persons with developmental disabilities are entitled to receive diagnosis, counseling, comprehensive case management, and community support services related to their developmental disability. These services are provided statewide under contracts with 21 Regional Centers that rely on existing public and private community health care resources to deliver medically related services. When Medi-Cal members qualify for these services, the Contractor is required to manage and coordinate care.

Medi-Cal Home and Community Based Services Waiver for Persons with Developmental Disabilities

The Medi-Cal Home and Community Based Services (HCBS) Waiver for persons with developmental disabilities is administered by the State Department of Developmental Services (DDS). This program provides intensive community based services for a limited number of developmentally disabled Medi-Cal beneficiaries who live in the community but are at risk for institutional placement. Services provided under this waiver include home health aide, personal care, respite care, habilitation, skilled nursing and non-medical transportation services. The Contractor is required to provide ongoing case management in coordination with the local Regional Center. If the Regional Center concurs with the Contractor's assessment of the Medi-

e. All RFP attachments that require a signature must be signed in ink, preferably in a color other than black.

1) Have a person who is authorized to bind the proposing firm sign each RFP attachment that requires a signature. Signature stamps are not acceptable.

2) Place the originally signed attachments in the proposal set marked "Master".

3) The RFP attachments and other documentation placed in the additional proposal sets may reflect photocopied signatures.

4) For the CD-R copy: Any document requiring a signature or any document that cannot be electronically copied should be scanned and placed on the CD as a PDF file.

f. Do not mark any portion of your proposal response, any RFP attachment or other item of required documentation as "Confidential" or "Proprietary". DHS will disregard any language purporting to render all or portions of a proposal confidential except as noted for financial information provided in response to technical proposal requirement item 2. Financial Information and item 8. Provider Compensation Arrangements.

DHS shall use its best efforts to preserve the confidentiality of the material. However, if required by a court order to disclose such material, DHS will comply with the court order.

3. Content requirements

This section specifies the order and content of each proposal. Assemble the materials in the following order for each county:

a. Proposal Cover Page

The Proposal Cover Page **(Attachment 1)** must be signed by a person authorized to bind the Proposer. If the Proposer is a corporation, a person authorized by the Board of Directors to sign on behalf of the Board must sign the cover page. Proposer must indicate which county the proposal is for on each Proposal Cover Page.

b. Table of Contents

Properly identify each section and the contents therein. Paginate all items in each section with the exception of those items placed in the Forms section.

c. Executive Summary section

This section must not exceed three (3) pages in length. In preparing your Executive Summary, do not simply restate or paraphrase information in this RFP. Describe or demonstrate, in your own words, the following information.

1) Your understanding of DHS' needs and the importance of this project.

2) The tangible results that you expect to achieve.

3) Your firm's sincere commitment to perform the scope of work in an efficient and timely manner.

4) How you will effectively integrate this project into your firm's current obligations and existing workload.

5) Why your firm should be chosen to undertake this work at this time.

d. Technical Proposal Requirements section

Respond to and submit each technical proposal item listed in the Technical Proposal Requirements section.

The technical proposal requirements are in numerical subject order. Each subject area is then arranged in alpha-numerical order. Proposer must number each technical response in the same sequential alpha-numerical format. The Proposer's technical response must be complete and arranged in sequential order and each response must be numbered with the corresponding number assigned to each technical proposal requirement item in the RFP. For example, the first technical proposal requirement in subject one (Organization and Administration of the Plan) must be denoted as "1.a."; the third item of the second technical proposal requirement in subject two (Financial Information) must be denoted as "2.b.3)".

All attachments must be referenced within the Proposer's technical response to the specific item, identified by the corresponding number of the technical proposal requirement item and submitted at the end of the subsection in which the technical response item is contained. For example, an attachment for the Proposer's technical response to subject 3 (Management Information System) first item would be submitted at the end of the item "3.a." and identified alpha-numerically as "Attachment 3.a. - A". If multiple attachments are submitted for a technical proposal requirement item, the Proposer must identify each individual attachment alpha-numerically "Attachment 3.a. - A, Attachment 3.a.- B", and so forth.

The Proposer's response to each technical proposal requirement item must be complete. Proposers cannot, in their technical response to a specific technical proposal requirement item, cross-reference to another technical response or attachment. Each technical response must be complete and stand-alone. Any deviation from the format/technical proposal requirements may result in rejection of the Proposer's Technical Proposal.

e. Forms section

Complete, sign and include the forms/attachments listed below. When completing the attachments, follow the instructions in this section and any instructions appearing on the attachment. After completing and signing the applicable attachments, assemble them in the order shown below.

Attachment and/or Documentation	**Instructions**
1- Proposal Cover Page	Complete the form, name of county, and include the signature of Bidder or Authorized Representative.

received and furnished for each entity; the accounting practices and disclosures for affiliated transactions, and the quarterly dollar amount of affiliate transactions by transaction type and affiliate.

b. Exhibit O: A statement describing how the organization will provide for separation of medical services from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management. Describe what controls will be put into place to assure compliance with this requirement. Include an organization chart with a narrative description of the organization that demonstrates medical decision makers are separate from the fiscal and administrative decision makers. The described organization should also demonstrate that the ability to make medical decisions is without undue influence from management responsible for administration and fiscal management (e.g., the Medical Director reports to the Chief Executive Officer or Chief Operating Officer, not the Chief Financial Officer, or Marketing Director.)
Title 28, CCR, Section 1300.51(d)(O)

c. Proposer shall provide a brief description of contracting experience within the past five years for services to Medicaid, (Medi-Cal), other Government programs, or other medically indigent or low income populations. Include contract duration, scope of services, health care delivery system models, number of members served, and geographical county.

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

a. Proposer shall provide a narrative and organization chart, which describes the Proposer's relationship with affiliated parties. The narrative shall include a description of services received from and furnished to Affiliates, the accounting practices and disclosures for affiliated transactions, and the quarterly dollar amount of Affiliate transactions by transaction type and Affiliate. If Proposer does not have Affiliate relationships provide a statement to that fact.

b. Current Financial Viability, including Tangible Net Equity: Proposer shall mark this item as "***Confidential and Proprietary***". Proposer shall provide the following Knox-Keene license exhibits reflecting current operation status:

1) Exhibit GG-1-a: most recent audited financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant, with financial statement footnotes included. In addition, Proposer shall prepare a Medi-Cal stand-alone line of business income statement for the most recent period being reported.

In addition to Exhibit GG-1-a: If Proposer is a publicly traded company, submit the most recent 10-K as filed with the Securities Exchange Commission.

2) Exhibit GG-1-b (**only if** the financial statements in Exhibit GG-1-a are for a period ended more than 60 days before the date of filing of this proposal): Quarterly financial statements as of the date of the last financial audit to present, consisting of a balance sheet, an income statement, statement of cash flows, and accompanying footnote disclosures. If prepared in accordance with GAAP

standards, the financial statements do not require certification. In addition, Proposer shall prepare a Medi-Cal stand-alone line of business income statement for the most recent period being reported.

For Proposers with an annual year end that is more than 60 days prior to the proposal submission date, and the submission date is prior to the date quarterly financial statements are available, submit the most recent fiscal year end financial statements.

DHS shall use its best efforts to preserve the confidentiality of the material. However, if required by a court order to disclose such material, DHS will comply with the court order.

3) Exhibit GG-2: calculation of TNE in accordance with Title 28, CCR, Section 1300.76, based on the most recent balance sheet provided as Exhibit GG-1-a or b.

Title 28, CCR, Section 1300.51(d)(GG)

c. Projected Financial Viability: Proposer shall provide the following Knox-Keene license exhibits reflecting projected viability:

1) Exhibits to Substantiate Assumptions and Conclusions to Financial Projections. **Submit the following items only if the organization has not been operational for 3 years; has not had a profitable operation in California during the last three years; or, has never provided Medi-Cal Managed Care services as a contractor or sub-contractor.**

a) Exhibit HH-3-a: Complete results of feasibility studies obtained as normally required by conventional lending institutions, including at least legal, marketing/enrollment, providers, and financial feasibility studies.

b) Exhibit HH-3-b: Actuarial report that includes at least the following information for all enrollees as covered by contracts which are community rated:

i. Utilization rates for each medical expense item reflected in Proposer's projected income statement. Express the rates in terms of utilization units per member, per month. Include methodology and source of data used to determine such rates.

ii. Cost per utilization unit for each medical expense item reflected in the income statement. Include methodology and source of data used to determine such costs.

iii. Per member, per month cost for each medical expense item.

iv. Methodology and source of data used to estimate co-payments, coordination of benefits, and reinsurance recoveries, including the expression of such items on a per member, per month basis.

v. Inflation estimates used in the projections and source utilized to determine such estimates.

c) Exhibit HH-3-c: For each experience rated contract, attach an actuarial report for the contract which conforms to the requirements stated in Item HH-3-b.

d) Exhibit HH-3-d: A summary schedule which reflects the breakdown of the total revenue and expense included in the projected income statements in Exhibit HH-2-b by community rated contracts and experience rated contracts.

e) Exhibit HH-3-e: The assumptions made to determine the time lag between the delivery by covered health care services and Proposer's payment for those services. Also indicate all other assumptions made in preparing the projected cash flow statements in Item HH-2-c.

f) Exhibit HH-3-f: Description and Disclosure of Compliance with Tangible Net Equity Requirements:

i. Exhibit HH-3-f-i: A detailed description of any measures taken or proposed to be taken to maintain compliance with the tangible net equity requirement under Title 28, CCR, Section 1300.76 and the financial viability requirement under Title 28, CCR, Section 1300.76.1 in view of losses and expenditures prior to reaching a break-even point in operations. This information should include a schedule setting forth the amounts of any additional needed funding and the dates when such amounts will be infused into Proposer.

If such arrangements involve arrangements for additional capital, to subordinate or postpone the payment of accounts, notes or other obligations of the plan or other agreements, attach copies of such agreements or proposed agreements, identifying their applicable provisions, and identify the parties thereto and their relationship to the plan and its affiliates.

ii. Exhibit HH-3-f-ii: If any funding is to be obtained from an entity other than a national bank or a bank incorporated under the laws of this State, attach a copy of such entity's most recent annual audited and quarterly unaudited financial statements.

2) Exhibit HH-4 (Projected Reimbursements): Include the following information regarding projected reimbursements:

a) Monthly and quarterly projected reimbursements (cash basis). Refer to California Health & Safety Code, Section 1377(a) for items i. through iii. Include:

i. Payments to reimburse non-contracting providers for covered health care services furnished to Medi-Cal members.
ii. Payments to reimburse Medi-Cal members for covered health care services furnished by non-contracting providers.
iii. Total reimbursements for services by non-contracting providers (i.) plus (ii.).
iv. Fee-for-service payments to reimburse contracting providers for covered health care services.
v. Total reimbursements (iii.) plus (iv.).
vi. Total expenditures by Proposer for covered health care services.
vii. The ratio of total reimbursements to total health care expenditures (v.) divided by (vi.).
viii. The ratio of reimbursements for services by non-contracting providers to total expenditures (iii.) divided by (vi.).

b) Describe and substantiate the facts and assumptions upon which the projections are based, including those for fee-for-service payments to contracting providers and document the source and validity of such assumptions. (Actuarial studies or comparable information should be furnished in response to these items.).

c) In addition to Exhibit HH-4, part b., include a description of the Proposer's reimbursement arrangement with providers and all subcontractors, including any financial incentives. For providers who are to be paid per claim or per diem, include a description on how Proposer determines the provision for incurred, but not reported (IBNR) claims.

3. Management Information System

a. Proposer shall provide an organization chart of proposed or existing staffing for the MIS and Claims Department(s). Identify the position(s) and person(s) responsible for the MIS system reporting relationship between providers/sites and plan operations. Include the reporting relationship(s) of staff involved in the collection and processing of the data. Job descriptions should include reference to MIS functions and/or oversight activities as appropriate to either the MIS or Claims Processing Department.

b. Proposer shall provide an overview of the MIS including the hardware and software used and how each is related to other components of the system; i.e., service bureau, LAN system, mini-computer mainframe, etc.

c. Proposer shall provide a summary description of the proposed and/or existing MIS including a description of the components, related levels of automation or manual operation, and the linkages between subsystems (i.e., Financial; Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Assurance/ Utilization; and, Report Generation).

4. Quality Improvement System

a. Proposer shall submit an organization chart showing key staff and the committees and bodies responsible for Quality Improvement (QI) Activities including reporting relationships of the Quality Improvement System (QIS) committee(s) and staff within the Proposer's organization. Include qualifications for key positions.

b. Proposer shall provide an example of a recent quality of care issue involving a physician. Include how the issue was discovered, reported, and communicated through the QI committees to reach resolution.

c. Proposer shall describe its oversight and monitoring of QI activities that have been delegated to other entities, which have been undertaken over the past year. Provide specific examples of oversight and monitoring activities.

d. Proposer shall describe experience with Medi-Cal Health Plan Employer Data and Information Set (HEDIS). Describe internal chart retrieval process and provide Medi-Cal scores for the HEDIS data collected in the year 2000, for the following 7 measures;

1) Initiation of Prenatal care
2) Prenatal care in the first trimester
3) Check-ups after Delivery

4) Childhood Immunization Status Combination 2 - 4:3:1:2:3:1 series
5) Well Child Visits in the First 15 Months of Life (6 or more visits)
6) Well-Child Visits in the 3rd, 4th, 6th year of life
7) Adolescent Well-Care Visits

If Medi-Cal scores are not available, provide HEDIS scores for another product line. Identify the product line, service area and date of score.

e. Proposer shall describe how they integrate their consumer satisfaction survey findings into the QIS program. Provide examples of activities taken as a result of consumer satisfaction findings.

f. Proposer shall describe any innovative QI activities that demonstrate their commitment to exceeding the minimum requirements as set forth in the Contract.

5. Utilization Management

a. Proposer shall describe its Utilization Management (UM) system including organizational structure and placement in the organization. Proposer shall reference where this organizational component is presented in the organization chart required in technical proposal requirement 1.a.2)a). Narrative should include an explanation of the functions of the UM staff, and the relationship of UM to the other parts of the organization.

b. Proposer shall submit a UM log and reports reflecting prior authorizations for the most recently completed three month period that includes the following information:

1) Prior authorization requests submitted, approved, deferred, denied or modified.
2) Turnaround times for the adjudication of the pre-authorization requests mentioned above.
3) Denials that were appealed and overturned.

c. Proposer shall describe what UM activities are delegated to subcontractors. Describe how oversight, tracking, and monitoring of the delegated activities are conducted. Provide a sample report from a delegated entity that illustrates UM activity performance.

d. Proposer shall describe any innovative UM activities that demonstrate their commitment to exceeding the minimum requirements as set forth in Contract.

6. Provider Network

a. Proposer shall submit a map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) used should be of convenient size and of the largest scale sufficient to include the entire proposed Service Area in which eligible Medi-Cal members live. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas and regions of the state, such as those commonly available from automobile associations or retail service stations, are preferred. The maps shall show:

1) Geographic detail, including highways and major streets.

2) Boundaries of proposed county.

3) Location of any contracting or plan-operated hospital and, if separate, each contracting or plan-operated emergency health care facility. Hospitals are to be designated by an "H" and emergency care facilities by an "E."

4) Location of Primary Care Providers, designated by a "P" (for providers who have signed subcontracts) or "PL" (for primary care providers who have submitted letters of intent). For convenience, the Primary Care Providers within any mile-square area may be considered as one location within that area.

5) Location of after-hours urgent care centers, designated by a "U."

6) Location of all other contracting or plan-operated health care providers including the following:

a) Pharmacy, designated by an "Rx."
b) Laboratory, designated by an "L."
c) Eye Care, designated by an "O."
d) Specialists and ancillary healthcare providers, designated by an "S."

Add an "L" for providers who have submitted a letter of intent; i.e., Pharmacy "RxL," Laboratory "LL," Eye Care "OL."

b. Proposer shall submit an index to the map(s) furnished in item a. above which shows, for each symbol placed on the map for a Primary Care Provider, specialist, ancillary provider, hospital, or emergency care facility, the following information:

1) For each symbol for Primary Care Providers, identify the type of Primary Care Provider (physician, family nurse practitioner, physician assistant), give the number of full-time equivalent Primary Care Physicians available to Medi-Cal members, and the aggregate number of Medi-Cal members those Primary Care Physicians will accept.

2) Identify all providers who are Traditional or Safety-Net Providers.

3) Identify the types of specialists (Cardiology, Endocrinology) and ancillary healthcare providers (physical therapy, durable medical equipment).

c. Proposer shall submit lists of Physicians who will provide covered physician services to Medi-Cal members. Lists must be arranged by Physician specialty and by zip code. Provide separate lists for Primary Care Physicians and specialists.

Proposers must submit provider information in hard copy and electronic media using the report form in Program Appendices, Appendix 12, Primary Care Physicians, and Appendix 13, Physicians - Specialists. All electronic media must be submitted on a 3.5 inch diskette or CD and in Microsoft Excel or Access formats (1997 or 2000 version) or in an ASCII text format. SeeProgram Appendices, Appendix 14 for file layout. For each Physician, furnish the following information: (Use a separate row for each location at which a provider practices.)

1) Name. (Last, First)

2) Professional license number.

3) Medi-Cal identification number, if applicable.

4) Group name: Name of physician group affiliation or indicate if Physician is independent.

5) Type of service as determined by board certification and eligibility.

6) Plan-owned or contracting hospitals at which the Physician has admitting staff privileges.

7) Professional address of the Physician.

8) Business hours of the Physician's office (i.e., Monday through Friday 8:00 A.M. to 5:00 P.M., closed Wednesdays).

9) Number of full-time equivalent non-physician medical practitioners under the supervision of the Physician.

10) Total number of active patients.

11) Current number of active Medi-Cal patients.

12) Total number of new Medi-Cal members the Physician will agree to accept from the Proposer. (Not required for specialists.)

13) Indicate if Physician is a Traditional or Safety-Net Provider.

14) Languages spoken in Physician's office.

Submit GeoAccess (or similar software) generated reports and maps using the above Primary Care Physicians data and the Medi-Cal Eligibility file (month of eligibility: June 2002) data (see Appendix 2, Data Library Catalog, item 12.)

d. Proposer shall submit a list of all non-physician medical practitioners including nurse practitioners, nurse midwives, and physician assistants in the proposed network. Lists must be arranged by the supervising Physician's specialty (or for midwives', advisory physician's specialty) and by zip code. Proposers must submit information in hard copy using the report form in Program Appendices, Appendix 15, Non-Physician Medical Practitioners. For each non-physician medical practitioner, furnish the following information:

1) Name. (Last, First)

2) Type of License/Certification with Expiration Date.

3) Name of physician group affiliation or indicate if employed by an independent Physician.

4) Name of supervising or advising Physician.

5) Medi-Cal identification number, if applicable.

6) Work Location (address).

7) Hours available (i.e., Monday through Friday 8:00 A.M. to 5 P.M., closed Wednesdays).

8) Total number of patients.

e. Proposer shall submit a list of all other providers of health care services not included in the Physician, non-physician medical practitioner, and hospital listings who will provide services to Medi-Cal members. Submit the following information:

1) Name.

2) Street address of the provider, and a list of facility sites at which services are rendered.

3) Business classification (such as: professional corporation, sole proprietor, partnership).

4) License number.

5) The health care services it provides to enrollees of the plan (e.g., home health agencies, ambulance company, laboratory, pharmacy, skilled nursing facility, surgery-center, mental health, family planning, etc.).

6) Hours of operation and the provision made for after-hours service (i.e., Monday through Friday 8-5, closed Wednesdays).

7) Relationship to the Contractor (owned by, contracting with, etc.)

8) If entity is a Traditional or Safety-Net Provider.

f. Proposer shall submit the following information for each hospital providing services to Medi-Cal members:

1) Legal name and any "DBA" ("doing business as").

2) Address.

3) License number.

4) Proof of membership with the American Hospital Association or proof of accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the expiration date of its current accreditation.

5) Bed capacity.

6) Emergency room capabilities.

7) List full description of all services available to Medi-Cal Members. Proposer may use a JCAHO form or the equivalent.

8) Relationship with Proposer or Proposer's subcontractor.

9) If hospital is a disproportionate share hospital.

g. Proposer shall provide an overview of how the network presented in this proposal meets Contract requirements. In addition include:

1) Potential barriers to Primary Care, specialty care, and hospital service access. Describe any solutions for overcoming barriers.

2) Manner in which network promotes ease of access to Primary Care locations, specialty care, and hospital service access.

3) Arrangements for out-of-network specialty care.

h. Proposer shall submit a calculation of the adequacy of its provider arrangements or provider network to serve a minimum 60 percent of the county's total mandatory and voluntary eligible beneficiaries. See Program Appendices, Appendix 7, Demographics. Describe how Proposer will monitor Primary Care Physician capacity overall (across all providers) and what short term and long term actions will be taken when capacity problems are identified

i. Proposer shall describe how it will meet program objectives as described earlier under the Medi-Cal Managed Care Program regarding the inclusion of Traditional and Safety-Net Providers within its network. Include:

1) Process for identifying Traditional and Safety-Net Providers in Proposer's network.

2) Role that Proposer perceives Traditional and Safety-Net Providers assuming in the health plan.

3) Proportion of Proposer's network that Traditional and Safety-Net Providers comprise.

4) Modifications, if any, that Proposer will make to standard health plan policies to allow inclusion of Traditional and Safety-Net Providers' participation.

5) Proposer's plan for equitable assignment of Members who do not voluntarily select a Primary Care Provider to a Traditional or Safety-Net Provider.

6) Any additional information demonstrating Proposer's commitment to a partnership with Traditional and Safety-Net Providers.

j. Proposer shall provide any additional information that demonstrates the health plan's commitment to excellence and exceeding the minimum requirements as set forth in the Contract (Exhibit A, Attachment 6). Include a discussion of existing resources or proposed changes that will achieve a provider network which fully supports the goals and objectives of DHS. Provide any examples of processes, ideas, visions, or organizational goals that make the health plan unique among providers of similar services.

7. Provider Relations

a. Proposer shall describe processes for meeting requirements and responsibilities to keep providers informed and updated regarding Medi-Cal policies, procedures, and regulations. Discuss provider orientation, training, and education on the Medi-Cal program. Include frequency of training and any materials such as

agendas, curricula or provider manuals that demonstrate Proposer's commitment to provider education and training.

b. Proposer shall describe the duties of the provider services function. Include hours of operation.

c. Proposer shall describe its current process for intake and resolution of Provider Grievances.

8. Provider Compensation Arrangements

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

a. Proposer shall mark this item as ***"Confidential and Proprietary"*** Proposer shall explain/disclose how contracting providers are likely to be compensated. Proposer should include the associated scope of services for each of the contracted provider types. The information should be consistent with the information submitted in technical proposal requirement 6, Provider Network, item b. Include the schedules of capitation rates, per diem rates and/or fee-for-service rates for each of the following provider types:

1) Primary Care Providers
2) Medical Groups and Independent Practice Associations
3) Specialists
4) Hospitals
5) Pharmacies

DHS shall use its best efforts to preserve the confidentiality of the material. However, if required by a court order to disclose such material, DHS will comply with the court order.

b. Proposer shall submit their expected overall medical expense ratio ***(Total Medical Expenses / Total Revenues)*** for the proposed Service Area based on the expected compensation arrangements with their provider network. The expected compensation arrangements used in determining the medical expense ratio should be consistent between the compensation arrangements cited in technical proposal requirement a. above.

c.1. Proposer shall provide a claims history report for at least the last six months, the report should identify the percentage of "clean" claims paid within 30, 60 and 90 days of receipt.

c.2. Proposer shall also report the average number of claims processed per month, the number of denials per month as well as the number of provider claims appeals received per month, for the last six months.

d. Proposer shall describe any compensation incentive or reward programs paid to providers based on quality, timely access to care, financial performance or any other measure.

9. Access and Availability

a. Proposer shall describe its current accessibility standards relative to appointments for:

1) Routine Care
2) Urgent Care
3) Referral appointments to specialists
4) Prenatal Care
5) Children's Preventive Periodic Health Assessments according to the American Academy of Pediatrics.
6) Initial Health Assessment

b. Proposer shall describe how it will communicate, enforce and monitor provider compliance with accessibility standards mentioned above.

c. Proposer shall describe past experience in providing services to culturally and linguistically diverse populations.

d. Describe current and/or proposed policies and procedures for the provision of cultural and linguistic services to meet the needs of the Medi-Cal population.

e. Proposer shall describe any innovative access and availability activities that demonstrate their commitment to attaining quality and exceeding the minimum requirements as set forth in the Contract.

10. Scope of Services

a. Proposer shall describe the system to ensure that all new Medi-Cal members receive an Initial Health Assessment (IHA) by an appropriate Primary Care Provider within the timeframes required for the age and/or medical condition of the new Medi-Cal member. The description shall include the processes used by Proposer to monitor the actual performance of the system and the methodologies used to overcome common barriers that prevent the receipt of the IHA by the Medi-Cal member.

b. Proposer shall describe methodologies used to ensure that all Medi-Cal members receive recommended Preventive Care services within appropriate timeframes. The response must include the following:

1) Description of Preventive Care services appropriate for each relevant age group.
2) Methodologies used to ensure provision of current and future recommended Preventive Care services within appropriate timeframes.
3) Current rates of utilization.
4) Incentives that have been offered.
5) Follow-up processes that are used to "follow-up" Medi-Cal members' lack of compliance.
6) Methods that have been used to improve utilization rates.

c. Proposer shall describe current and or proposed policies regarding prenatal risk assessments. The response should include the following:

1) A copy of the proposed prenatal risk assessment tool.
2) Strategies conducted to ensure assessments are done as required.
3) To whom and where women at high risk of poor pregnancy outcomes are referred for appropriate specialty care.

d. Proposer shall describe its health education program. Describe how health education is incorporated into the Proposer's health care service and delivery

system. Describe any initiatives designed to target Medi-Cal members with limited English proficiency and/or cultural differences.

11. Case Management and Coordination of Care

a. Proposer shall describe its case management system including organizational structure and placement in the organization. Proposer shall reference where this organizational component is presented in the organization chart required in technical proposal requirement 1.a.2)a). Narrative should include an explanation of the functions of the case management staff, lines of reporting responsibility, and relationship interaction with other program areas in the health plan.

b. Proposer shall describe its current experience with the programs listed below. Describe current and/or proposed procedures to initiate and maintain coordination of care with the programs, including communication, information sharing and problem resolution.

1) Early and Periodic Screening Diagnosis and Treatment Targeted Case Management Services
2) County Mental Health Services or Local Mental Health Plan
3) California Children Services

c. Proposer shall describe methodologies used to implement disease management systems (including self-care) for Medi-Cal members. Include the following:

1) Description of the programs.
2) Impact of the intervention
3) Description of new programs proposed for the Medi-Cal population.

d. Proposer shall indicate case management and coordination of care services that will be delegated to network subcontractors or contracted to vendors. Describe Proposer's oversight of delegated or subcontracted activities.

12. Local Health Department Coordination

There are no technical proposal requirements for Local Health Department Coordination.

13. Member Services

a. Proposer shall submit an organization chart showing the placement of staff responsible for member services functions within the organizational structure of the plan. Include a description of the functions of member services positions and lines of reporting responsibility. Indicate the ratio of member services representatives (MSRs) to all enrolled members.

b. Proposer shall describe its experience and proposed process for the following:

1) Translation of written member materials.
2) Assessment and application of appropriate readability levels.
3) Hiring multi-lingual MSRs.

c. Proposer shall provide a description of its call center and mechanisms for monitoring the quality of service provided by the MSRs. Submit a call center report that indicates the following for the most recently completed three month period.

1) The number of calls received by call type (i.e. questions, grievances, access to services, requests for health education, etc.).
2) Average speed in which calls to the call center are answered with a live voice.
3) Call center abandonment rate, monthly average number of calls received into the call center and abandoned by caller after being placed on hold.

d. Proposer shall provide any innovative member services activities that demonstrate their commitment to attaining quality and exceeding the minimum requirements as set forth in the Contract.

14. Member Grievance System

a. Proposer shall provide an overview of the staff responsible for the grievance system.

1) Identify the officer of the health plan designated as having primary responsibility for the maintenance of the grievance system. Describe scope of responsibility including oversight and role in grievance process.
2) Identify staff responsible for processing grievances and their role in the Quality Improvement System.
3) Describe the oversight mechanism of the system to ensure that regulatory grievance resolution timelines are met.

b. Proposer shall describe a type of grievance reported in the past that was determined to be a trend. Give an explanation of how the trend was identified and resolved. Please include the steps taken to prevent the trend from reoccurring.

c. Proposer shall provide any innovative member grievance system activities that demonstrate their commitment to attaining quality and exceeding the minimum requirements as set forth in the Contract.

15. Marketing and
16. Enrollments & Disenrollments

There are no technical proposal requirements for Marketing or Enrollments and Disenrollments sections.

17. Reporting Requirements

There are no technical proposal requirements for Reporting Requirements.

18. Implementation Plan and Deliverables

There are no technical proposal requirements for the Implementation Plan and Deliverables.

M. Proposal Submission

1. General Instructions

a. Assemble your proposal together as instructed in Section K. Proposal Format and Content Requirements. Place the proposal set marked "Master" on top, followed by the Reference Set, the three (3) extra copies, and then the CD-R copy.

b. Place all proposal copies in a single envelope or package, if possible. Seal the envelope or package.

If you submit more than one envelope or package, carefully label each one as instructed below and mark on the outside of each envelope or package "1 of X", "2 of X", etc.

c. Mail or arrange for hand delivery of your proposal to the Department of Health Services, Office of Medi-Cal Procurement. Proposals may not be transmitted electronically by fax or email.

d. The Office of Medi-Cal Procurement must receive your proposal, regardless of postmark or method of delivery, by **4:00 p.m. on April 14, 2003**. Late proposals will not be reviewed or scored.

e. Label and submit your proposal using one of the following methods.

Hand Delivery or Overnight Express:	**U.S. Mail:**
Proposal RFP 02-25804 Department of Health Services Office of Medi-Cal Procurement Attn: Subran Singh 600 North 10th Street, Room 240-C Sacramento, CA 95814-0393	**Proposal RFP 02-25804** Department of Health Services Office of Medi-Cal Procurement Attn: Subran Singh 600 North 10th Street, Room 240-C P.O. Box 942732 Sacramento, CA 94234-7320

f. **Proposer warning**

DHS' internal processing of U.S. mail may add up to 48 hours to the delivery time. If you mail your proposal, DHS recommends using certified or registered mail and requesting a receipt upon delivery. If you choose hand delivery, allow sufficient time to locate parking and to sign-in at the security desk.

2. Proof of timely receipt

a. DHS staff will log and attach a date/time stamped slip or bid receipt to each proposal package/envelope received. If a proposal envelope or package is hand delivered, DHS staff will give a bid receipt to the hand carrier upon request.

b. To be timely, DHS' Office of Medi-Cal Procurement must receive each proposal at the stated delivery address no later than 4:00 p.m. on the proposal submission due date.

c. DHS will deem late proposals nonresponsive.

3. Proposer costs

Proposers are responsible for all costs of developing and submitting a proposal. Such costs cannot be charged to DHS or included in any cost element of a Proposer's price offering.